Bureau of Health Care Quality and Compliance

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED	
		NVS3363ALZ		A. BUILDING B. WING		05/1	; 3/2010
NAME OF PR	OVIDER OR SUPPLIER	NVOSSOALZ	STREET ADD	<b>I</b> RESS, CITY, STA	ATE, ZIP CODE	1 03/1	3/2010
	ALLEY ALZ CARE CENT	rer .	6428 CRYS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
Y 000	Initial Comments			Y 000			
	by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws.  This Statement of De a result of a complain your facility from 4/30 State Licensure surve	clusions of any investign shall not be construed all or civil investigations as for relief that may be under applicable feder diciencies was generated in the state of the sta	l as al, ed as ed in This e				
	Division.  The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 10. Eleven resident files were reviewed and five employee files were reviewed. Three discharged resident files were reviewed.						
	Complaint #NV00024 Tag Y0087.	614 was substantiated.	. See				
Y 050 SS=F	449.194(1) Administra Responsibilities-Over			Y 050			
	1. Provide oversight members of the staff to ensure that resider and protective supervin compliance with the	a residential facility shal and direction for the of the facility as necess its receive needed serv vision and that the facilit e requirements of NAC inclusive, and chapter	ary vices ty is				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
				A. BUILDING B. WING			
		NVS3363ALZ				05/1	3/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
I SDDING VALLEV ALZ CADE CENTED			6428 CRYS LAS VEGAS	TAL DEW S, NV 89118			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 050	This Regulation is no Based on interview, robservation from 4/30 administrator failed to direction to the staff to	ot met as evidenced by: ecord review and 0/10 to 5/13/10, the o provide oversight and o ensure 11 of 11 resid ervices and protective iired.		Y 050			
Y 087 SS=I	NAC 449.199 3. A residential facility accept residents in expumber of residents solicense issued to the facility.	xcess of the specified on the	nts	Y 087			
	Based on observation interview from 4/30/10 over census during M Findings include:  The facility is licensed residents, Category 2	0 to 5/13/10, the facility larch of 2010. d for 10 beds for Alzhei	was mer's				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		NVS3363ALZ		B. WING		_	, 3/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
SPRING V	ALLEY ALZ CARE CENT	ER	6428 CRYSTA LAS VEGAS,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDER OF THE APPROFIDER OF THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
Y 087	10 residents residing resident was admitted the facility to be over During an interview of administrator stated the state of the state	ission and discharge that on 3/12/10, there win the facility. An elever of on 3/13/10. This caust census by one resident on 4/30/10, the facility's that the facility was over ont in March of 2010 for	vere nth sed	Y 087			
Y 100 SS=A	NAC 449.200  1. Except as otherwis a separate personnel member of the staff or (a) The name, address social security number.  This Regulation is not Based on record reviet the facility failed to prefile for 1 of 5 employer. This was a repeat def State Licensure surveil.	of met as evidenced by: ew from 4/30/10 to 5/13 ovide a separate perso es (Employee #5). ficiency from the 3/24/0 ey.	on 2, ach lude: nd	Y 100			
Y 103 SS=E	449.200(1)(d) Person	nel File - NAC 441A /		Y 103			

_	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUR\	
		NV (00000 A L 7		B. WING		C	(00.10
NAME OF DE	OVIDER OR SUPPLIER	NVS3363ALZ	STREET ADD	RESS, CITY, STA	ATE ZIP CODE	05/13/	/2010
	ALLEY ALZ CARE CENT	TER	6428 CRYS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 103	Continued From page	3		Y 103			
	a separate personnel member of the staff o	e provided in subsection file must be kept for east a facility and must incontact ates required pursuant for the employee.	ach lude:				
	Based on record reviet the facility failed to en complied with NAC 44 tuberculosis (TB) test residents (Employee	ing for the protection of #3 and #4). ficiency from the 3/24/0	3/10, f all				
	Severity: 2 Scope: 2	2					
Y 105 SS=F	449.200(1)(f) Personn	nel File - Background C	heck	Y 105			
	a separate personnel member of the staff of	e provided in subsection file must be kept for east a facility and must incliance with NRS 449.17	ach lude:				
	Based on record revie the facility failed to en	ot met as evidenced by: ew from 4/30/10 to 5/13 sure 3 of 5 caregivers quirements within 10 da 4 and #5).	3/10, met				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		NVS3363ALZ		B. WING		05/4	3/2010
NAME OF PR	OVIDER OR SUPPLIER	NVSSSOSALZ	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	03/1	3/2010
SPRING V	ALLEY ALZ CARE CENT	ER	6428 CRYS LAS VEGAS	TAL DEW S, NV 89118			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
Y 105	Continued From page	÷ 4		Y 105			
	Severity: 2 Scope: 3	3					
Y 450 SS=D	449.231(1) First Aid a	nd CPR		Y 450			
	NAC 449.231  1. Within 30 days afte administrator or caregoresidential facility is enthe facility, the adminicaregiver must be trainand cardiopulmonary advanced certificate in adult cardiopulmonary issued by the America equivalent certification accepted as proof of the summer of th	giver of a mployed at strator or ined in first aid resuscitation. The infirst aid and gresuscitation an Red Cross or an in will be					
	Based on record reviet the facility failed to en were trained in cardio within 30 days of emp	at met as evidenced by:  ew from 4/30/10 to 5/13  sure that 1 of 5 caregive  pulmonary resuscitation  bloyment(Employee #2)	rers n				
	Severity: 2 Scope: 1	l					
Y 859 SS=F	449.274(5) Periodic President	Physical examination of	a	Y 859			
	NAC 449.274 5. Before admission a admission, or more fre significant change in t		fa				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		NVS3363ALZ		A. BUILDING B. WING		05/1:	3/2010
NAME OF DE	ROVIDER OR SUPPLIER	NVOCCOALL	STREET ADD	<b>I</b> RESS, CITY, STA	ATE ZIP CODE		3/2010
	ALLEY ALZ CARE CENT	TER	6428 CRYS		, = 0052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 859	Continued From page	e 5		Y 859			
	general physical exar his physician. The re	hall obtain the results o mination of the resident esident must be cared f actions provided by the	by				
	Based on record reviet the facility failed to en residents received a president #1, #4, #8, failed to ensure that 2 facility for longer than physical (Resident #1). This was a repeat de State Licensure surve Severity: 2 Scope: \$2.449.2742(4) Medication 449.037. NAC 449.2742  4. Except as otherwise subsection, a caregive administration of medication resident needs the caregiver may assist controlled substances.	ficiency from the 3/24/0 ey.  3  3  3  4  5  5  6  6  7  8  8  8  8  8  8  8  8  8  8  8  8	s/10, sion cility n the nual	Y 876			
	This Regulation is no	ot met as evidenced by:					

			) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NVS3363ALZ		A. BUILDING B. WING	·	05/1	; 3/2010	
NAME OF PR	ROVIDER OR SUPPLIER	NV33303ALZ	STREET ADD	<b>I</b> RESS, CITY, STA	TE. ZIP CODE	[ 05/1	3/2010	
	ALLEY ALZ CARE CENT	ΓER	6428 CRYS	RYSTAL DEW GAS, NV 89118				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
Y 876	Continued From page	e 6		Y 876				
	Based on record reviethe facility failed to er agreement was obtai (Resident #1, #2 and	ew from 4/30/10 to 5/13 asure that an ultimate uned for 3 of 11 resident #4).  ficiency from the 3/24/0 ey.	ser s					
Y 896 SS=F	449.2744(1)(b)(2) Me	edication / MAR		Y 896				
	provides assistance t administration of med (b) A record of the me each resident. The re	dication shall maintain: edication administered	to					
	Based on record review the facility failed to er administration record	(MAR) was accurate fo dent #1, #2, #3, #4, #5,	8/10, or 10					
Y 899 SS=C				Y 899				

Bureau of Health Care Quality and Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		` ′	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		NV00000117		A. BUILDING B. WING		0.74	
		NVS3363ALZ	OTDEET ADD	DEGG OITY OTA	TE 710 000E	05/1	3/2010
NAME OF PF	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE		
I SDDING VALLEY ALZ CADE CENTED			6428 CRYS	S, NV 89118			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 899	Continued From page	e 7		Y 899			
	of caregivers assigned that indicates the shift caregiver was responsional administration of mediate requirement may be resident's medication assisted the resident	sible for assisting in th lication to a resident. T	tions This who the				
Y 930 SS=A	Based on record reviethe facility failed to interest assisted the resident medications, for 10 of #2, #3, #4, #5, #6, #7  Severity: 1 Scope:  449.2749(1)(a) Reside Information  NAC 449.2749  1. A separate file must resident of a resident least 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, assessing	at be maintained for each ial facility and retained permanently leaves the be kept locked in a plate and is protected again the file must contain all	ch for at e ce est	Y 930			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/O			( , , , , , , , , , , , , , , , , , , ,		(X3) DATE SURVEY COMPLETED	
		NVS3363ALZ		A. BUILDING B. WING		05/13	3/2010
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
			6428 CRYS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 930	Continued From page	e 8		Y 930			
	the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident.						
	Based on record revie	ot met as evidenced by: ew on 5/13/10, the facil eparate resident file for nt #2).	ity				
		This was a repeat deficiency from the 3/24/09 State Licensure survey.					
	Severity: 1 Scope:	1					
Y 936 SS=F	449.2749(1)(e) Resid Tuberculosis	ent file-NRS 441A		Y 936			
	resident of a residentileast 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, assessinformation and any of the resident, including	other information related g without limitation: liance with the provision and the regulations	for at e ce st				
	Based on record reviet the facility failed to er complied with NAC 44	ot met as evidenced by: ew from 4/30/10 to 5/13 nsure 7 of 10 residents 41A.380 regarding Resident #1, #2, #3, #4	3/10,				

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET		
				B. WING		C	
		NVS3363ALZ	OTDEET ADD	DEGG OITY OTA	ATE 710 000E	05/1	3/2010
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE		
			6428 CRYS	S, NV 89118			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 936	Continued From page 9			Y 936			
	#8 and #10) which affected all residents.						
	This was a repeat deficiency from the 3/24/09 State Licensure survey.						
	Severity: 2 Scope: 3						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.